Case Example 1

Mrs. K is a 92 year old widow of 30 years who has severe functional dependency secondary to heart disease. Her primary nurse assistant has reported during the last two days Mrs. K has "not been herself." She has been napping more frequently and for, longer periods during the day. She is diicult to arouse and has mumbling speech upon awakening. She also has difficulty paying attention to what she is doing. For example, at meals instead of eating as she usually does, she picks at her food as if she doesn't know what to do with a fork. Then stops and closes her eyes after a few minutes. Alternatively, Mrs. K has been waking up at night believing it to be daytime. She has been calling out to staff demanding to be taken to see her husband (although he is deceased). On 3 occasions Mrs. K was observed attempting to climb out of bed over the foot of the bed.

Indicators	Coding
a. Easily distracted	2 (present, new)
b. Periods of altered perception or awareness of surroundings	2 (present, new)
c. Episodes of disorganized speech	2 (present, new)
d. Periods of restlessness	2 (present, new)
e. Periods of lethargy	2 (present, new)
f. Mental function varies over the course of the day	2 (present, new)

Case Example 2

Mr. D has a history of Alzheimer's disease. His skills for decision making have been poor for a long time. He often has difficulty paying attention to tasks and activities and usually wanders away from them. He rarely speaks to others, and when he does it is garbled and the contents are nonsensical. He is often observed mumbling and moving his lips as if he's talking to someone. Although Mr. D is often restless and fidgety this behavior is not new for him and it rarely interferes with a good night's sleep.

Indicators	Coding
a. Easily distracted	1 (present, not new)
b. Periods of altered perception or awareness of surroundings	1 (present, not new)
c. Episodes of disorganized speech	1 (present, not new)
d. Periods of restlessness	1 (present, not new)
e. Periods of lethargy	0 (behavior not present)
f. Mental function varies over the course of the day	1 (present, not new)

6. Change in Cognitive Status

Intent: To document changes in the resident's cognitive status, skills, or abilities as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). These can include, but are not limited to, changes in level of consciousness, cognitive skills for daily decision-making, short-term or long-term memory, thinking or awareness, or recall. Such changes may be permanent or temporary; their causes may be known (e.g., a new pain or psychotropic medication) or unknown If the resident is a new admission to *the* facility, this item includes changes during the period prior to admission.

Coding: Record the number corresponding to the most correct response. Enter "0" for No change, "1" for Improved, or "2" for Deteriorated.

Examples of Change in Cognitive Status

Mrs. G experienced delirium (acute confusion) secondary to pneumonia approximately 30 days ago. With appropriate antibiotic therapy, hydration, and a quiet supportive milieu, she recovered. Although Mrs. G's cognitive skills did not increase beyond the level that existed prior to her pneumonia, and she remains unable to make daily decisions, she has steadily improved to her pre-pneumonia status. **Code "0" for No Change.**

Ms. P is intellectually intact. About two and one-half months ago she was informed by her daughter that her neighbor and lifelong friend had died while on a trip to Europe. Ms. P took the news very hard; she was stunned and seemed to be confused and bewildered for days. With support of family and staff, confusion passed. Although she continued to grieve, her cognitive status returned to what it was prior to her receiving the bad news. Code **"0"** for No **change.**

Mr. D was admitted to the nursing home three months ago upon discharge from the hospital with signs of post-operative delirium. Since that time he no longer requires frequent reminders and re-orientation throughout each day. His decision-making skills have improved. **Code "1" for Improved.**

Mr. F has Alzheimer's disease. He did well until two months ago, when his primary nurse assistant reported that he can no longer find his way back to his room; which he was able to do three months ago. He often gets lost now while trying to find his way to the unit activity/dining room. Code **"2" for Deteriorated.**

(continued on next page)

Examples of Change in Cognitive Status
(continued)

Mrs. F was admitted to the facility six weeks ago. Upon admission she had modified independence in daily decision-making skills, intact short and long term memory, and good recall abilities. Since that time, Mrs. F has had a stroke, which has left her with deficits in these areas. Within this Significant Change assessment period, her decisions have become poor. She is not aware of her new physical limitations and has taken unreasonable safety risks in transferring and locomotion. She receives supervision at all times. Code **"2"** for Deteriorated.

MDS Cognitive Performance Scale©

Many facilities have asked for a system to combine MDS cognitive items into an overall Cognitive Performance Scale. Such a scale has been produced — The MDS Cognitive Performance Scale (CPS)© [see Appendix F]. Five MIX items are used in assigning residents to one of seven CPS categories. The CPS categories are highly related to residents' average scores on the Folstein Mini-Mental Status Examination (MMSE), which has a score range of zero (worst) to thirty (best). According to Folstein, an MMSE score of 23 or lower usually suggests cognitive impairment but it may be lower for persons with an eighth grade education or less.

SECTION C.
COMMUNICATION/HEARING PATTERNS

Intent: To document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others.

There are many possible causes for the communication problems experienced by elderly nursing home residents. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a resident might have aphasia as well as long standing hearing loss; or he or she might have dementia and word finding difficulties and a hearing loss. The resident's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in fmding the right word, makiig sentences, writing, and gesturing.

1. Hearing

Intent: To evaluate the resident's ability to hear (with environmental adjustments, if necessary) during the past seven-day period.

Process: Evaluate hearing ability after the resident has a hearing appliance in place, if the resident uses an appliance. Review the clinical record. Interview and observe the resident, and ask about the hearing function. Consult the resident's family, direct care staff, and speech or hearing specialists. Test the accuracy of your findings by observing the resident during your verbal interactions.

Be alert to what you have to do to communicate with the resident. For example, if you have to speak more clearly,' use a louder tone, speak more slowly, or use more gestures, or if the resident needs to see your face to know what you are saying, or if you have to take the resident to a more quiet area to conduct the interview — all of these are cues that there is a hearing problem, and should be so indicated in the coding.

Also, observe the resident interacting with others and in group activities. Ask the activities personnel how the resident hears during group leisure activities.

Coding: Enter one number that corresponds to the most correct response.

0. Hears adequately — The resident hears all normal conversational speech, including when using the telephone, Watching television, and engaged in group activities.

1. Minimal difficulty — The resident hears speech at conversational levels but has difficulty hearing when not in quiet liiening conditions or when not in one-on-one situations.

2. Hears in special situations only — Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible.

3. Highly impaired/absence of useful hearing — The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

2. Communication Devices/Techniques

Definition: **Hearing aid, present and used** — A hearing aid or other assistive listening device is available to the resident and is used regularly.

Hearing aid, present and not used regularly — A hearing aid or other assistive listening device is available to the resident and is not regularly used (e.g., resident has a hearing aid that is broken or is used only occasionally).

Other receptive communication technique used (e.g., lip reading) — A mechanism or process is used by the resident to enhance interaction with others (e.g., reading lips, touching to compensate for hearing deficit, writing by staff member, use of communication board).

Process: Consult with the resident and direct care staff. Observe the resident closely during your interaction.

Coding: Check all that apply. If the resident does not have a hearing aid or does not regularly use compensatory communication techniques, check *NONE* OF ABOVE.

3. Modes of Expression

Intent: To record the types of communication techniques (verbal and non-verbal) used by the resident to make his or her needs and wishes known.

Definition: **Writing messages to express or clarify needs** — Resident writes notes to communicate with others.

Signs/gestures/sounds — This category includes nonverbal expressions used by the resident to communicate with others.

- Actions may include pointing to words, objects, people; facial expressions; using physical gestures such as nodding head twice for "yes" and once for "no" or squeezing another's hand in the same manner.

- **Sounds may** include grunting, banging, ringing a bell, etc.

Communication board — An electronic, computerized or other home-made device used by the resident to convey verbal information, wishes, or commands to others.

Other — Examples include flash cards or various electronic assistive devices.

Process: Consult with the primary nurse assistant and other direct-care staff from all shifts, if possible. Consult with the resident's family. Interact with the resident and observe for any reliance on non-verbal expression (physical gestures, such as pointing to objects), either in one-on-one communication or in group situations.

Coding: Check the boxes for each method used by the resident to communicate his or her needs. If the resident does not use any of the listed items, check NONE *OF ABOVE.*

4. Making Self Understood

Intent: To document the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation,' whether in speech, writing, sign language, or a combination of these.

Process: Interact with the resident. Observe and listen to the resident's efforts to communicate with you. Observe his or her interactions with others in different settings (e.g., one-on-one, groups) and different circumstances (e.g., when calm, when agitated). Consult with the primary nurse assistant (over all shifts) if available, the resident's family, and speech-language pathologist.

Coding: Enter the number corresponding to the most correct response.

0. Understood — The resident expresses ideas clearly.

1. Usually Understood — The resident has difficulty fmding the right words or finishing thoughts, resulting in delayed responses; or the resident requires some prompting to make self understood.

2. Sometimes Understood — The resident has limited ability, but is able to express concrete requests regarding at least basic **needs (e.g., food, drink, sleep, toilet).**

3. **Rarely or** Never Understood — At best, understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

5. Speech Clarity

Intent: To document the quality of the resident's speech, not the content or appropriateness -just words spoken.

Definition: Speech — the expression of articulate words.

Process: Listen to the resident. Confer with primary assigned caregivers.

Coding: Enter the number corresponding to the most correct response.

0. Clear speech — utters distinct, intelligible words.

1. **Unclear speech** — utters slurred or mumbled words.

2. No speech — absence of spoken words.

6. Ability to Understand Others

Intent: To describe the resident's ability to comprehend verbal information whether communicated to the resident orally, by writing, or in sign language or braille. This item measures not only the resident's ability to hear messages but also to process and understand language.

Process: Interact with the resident. Consult with primary direct care staff (e.g., nurse assistants) over all shifts if possible, the resident's family, and speech-language pathologist.

Coding: Enter the number corresponding to the most appropriate response.

0. Understands — The resident clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.

1. Usually Understands — The resident may miss some part or intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.

2. **Sometimes** Understands — The resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or &r&ions. When staff rephrase or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced.

3. Rarely/Never Understands — The resident demonstrates very limited ability to understand communication. Or, staff have difficulty determining whether the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

7. 'Change in Communication/Hearing

Inten t: **To** document any change in the resident's ability to express, understand, or hear information compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: In addition to consulting primary care staff (over all shifts if possible), consulting the family of new admissions, and reviewing prior Quarterly reviews when available, ask the resident if he or she has noticed any changes in the ability to hear, talk, or understand others. Sometimes, residents do not complain of changes being experienced because they attribute them to "old age". Therefore, it is important that they be asked directly. Some types of deterioration are easily corrected (e.g., by new hearing aid batteries or removal of ear wax).

Coding: Enter the number corresponding to the most correct response. Enter "0" for No change, "1" for Improved, or "2" for Deteriorated.

Examples of Change in Communication/Hearing

Mrs. L has had expressive aphasia for two years. Although she periodically says a word or phrase that is understood by others, this is not new for her. During the last 90 days her communication status has essentially remained unchanged. Code **"0"** for No change.

Mrs. R's hearing is severely impaired. Five months ago the occupational therapist developed flash cards for staff to use when communicating with her. This was a tremendous boost for both Mrs. R and staff. Her ability to understand others continues to improve. Code **"1"** for Improved.

Mr. S has complained for the last two weeks of ringing in his ears, saying "Please do something, it's driving me crazy! Code **"2"** for Deteriorated.

Upon adniission two months ago Mrs. T had difficulty hearing unless the speaker adjusted his or her tone of voice and spoke. more distinctly. She has worn hearing aids in the past but lost them during a hospital admission. Smce admission to the nursing home, Mrs. T was tested and fitted with hew hearing aids. She hears much better with the aids though she is still trying to adjust to wearing them. **Code "1" for Improved.**

SECTION D.
VISION PATTERNS

Intent: To record the resident's visual abilities and limitations over the past seven days, assuming adequate lighting and assistance of visual appliances, if used.

1. Vision

Intent: To evaluate the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., glasses, magnifying glass).

Definition: **"Adequate" lighting —** What is sufficient or comfortable for a person with normal vision.

Process:

- Ask direct care staff over all shifts if possible, if the resident has manifested any change in usual vision patterns over the past seven days — e.g., is the resident still able to read newsprint, menus, greeting cards, etc.?
- Then ask the resident about his or her visual abilities.
- Test the accuracy of your findings by asking the resident to look at regular-size print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (e.g., glasses, magnifying glass). Then ask the resident to read aloud, starting with larger headlines and ending with the fmest, smallest print.
- Be sensitive to the fact that some residents are not literate or are unable to read English. In such cases, ask the resident to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.
- If the resident is unable to communicate or follow your directions for testing vision, observe the resident's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the resident has any visual ability.

Coding: Enter the number corresponding to the most correct response.

0. Adequate — The resident sees fine detail, including regular print in newspapers/books.

1. Impaired — The resident sees large print, but not regular print in newspapers/books.

2. Moderately Impaired — The resident has limited vision, is not able to see newspaper headlines, but can identify objects in his or her environment.

3. Highly Impaired — The resident's ability to identify objects in his or her environment is in question, but the resident's eye movements appear to be following objects (especially people walking by).

Note: Many residents with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to "track" or follow moving objects in their environment with their eyes. For residents who appear to do this, use code "3", Highly Impaired. With our current limited technology, this is the best assessment you can do under the circumstances.

4. Severely Impaired — The resident has no vision; sees only light colors or shapes; or eyes do not appear to be following objects (especially people walking by).

2. Visual Limitations/Difficulties

Intent: To document whether the resident experiences visual limitations or difficulties related to diseases common in aged persons (e.g., cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurologic diseases). It is important to identify whether these conditions are present. Some eye problems may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the resident's residual visual abilities.

Process: Side vision **problems** — Observe the resident during his or her daily routine (e.g., eating meals, traveling down a hallway). Also, ask the resident about any vision problems (e.g., spilling food, bumping into objects and people). Ask the primary nurse assistant and other direct-care staff on each shift if possible, whether the resident appears to have difficulties related to decreased peripheral vision (e.g., leaves food on one side of tray, has difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self).

Experiences any **of the following** — Ask the resident directly if he or she is seeing halos or rings around lights, flashes of light, or "curtains" over the eyes. Ask staff members if the resident complains about any of these problems.

Coding: Check all that apply. If none apply, check *NONE OF ABOVE.*

3. Visual Appliances

Intent: To determine if the resident uses visual appliances regularly.

Definition: Glasses; contact lenses; magnifying glass — Includes any type of corrective device used at any time during the last seven days.

Coding: Enter "1" if the resident used glasses, contact lenses, or a magnifying glass during the past seven days. Enter "0" if none apply.

SECTION E.
MOOD AND BEHAVIOR PATTERNS

Mood distress is a serious condition and is associated with, significant morbidity. Associated factors include poor adjustment to the nursing home, functional impairment, resistance to daily care, inability to participate in activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress among elderly nursing home residents because they are very treatable.

In many facilities, staff have not received specific training in how to evaluate residents who have distressed mood or behavioral symptoms. Therefore, many problems are underdiagnosed and undertreated. In facilities where such training has not occurred, an in-service program under the direction of a professional mental health specialist is recommended. At a minimum, staff in such facilities have found the various mental health RAPs (e.g., Mood, Behavior) to be helpful and these should be carefully reviewed.

1. Indicators of Depression, Anxiety, Sad Mood

Intent: *To* record the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of psychicdistress may be expressed directly by the resident who is depressed, anxious, or sad. However, statements such as "I'm so depressed" are rare in the older nursing home population. Rather, distress is more commonly expressed in the following ways:

VERBAL EXPRESSIONS OF DISTRESS

a. **Resident made negative statements — e.g.,** "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."

b. **Repetitive' questions — e.g., "Where do I go; What** do I do?"

c. **Repetitive verbalizations — e.g.,** Galling out for help, ("God help me").

d. **Persistent anger with self or others — e.g., easily annoyed,** anger at placement in nursing home; anger at care received;

e. Self deprecation — e.g., "I am nothing; I am of no use to anyone".

f. Expressions of what appear to be unrealistic fears — e.g., fear of being abandoned, left alone, being with others.

g. Recurrent statements that something terrible is about to happen — e.g., believes he or she is about to die, have a heart attack.

h. Repetitive health complaints — e.g., persistently seeks medical attention, obsessive concern with body functions.

I. Repetitive anxious complaints/concerns (non-health related) — e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.

DISTRESS MAY ALSO BE EXPRESSED NON-VERBALLY AND IDENTIFIED THROUGH OBSERVATION OF THE RESIDENT IN THE FOLLOWING AREAS DURING USUAL DAILY ROUTINES:

SLEEP CYCLE ISSUES — Distress can also be manifested through disturbed sleep patterns.

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern — e.g., diiculty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep

SAD, APATHETIC, ANXIOUS APPEARANCE

1. Sad, pained, worried facial expressions — e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements — e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST. These items refer to a change in resident's usual pattern of behavior.

0. Withdrawal from activities of interest — e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction — e.g., less talkative, more isolated

Process: Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and will either tell someone about, their distress, or tell someone only when directly asked how they feel. Other residents may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe residents carefully for any indicator. Consult with direct-care staff over all shifts;. if possible, and family who have direct knowledge of the resident's behavior. Relevant information may also be found in the clinical record.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 30 days. Remember, code regardless of what you believe the cause to be.

0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week ***(i.e., exhibited at least once during the last 30 days but less than 6 days a week).***
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

Example

Mr. F is a new admission who becomes upset and angry when his daughter visits (3 times a week). He complains to her and staff caregivers that 'she put me in this terrible dump.' He chastizes her 'for not taking him into her home', and berates her 'for being an ungrateful daughter.' After she leaves, he becomes remorseful, sad looking, tearful, and says "What's the use. I'm no good. I wish I died when my wife did." Coding **"1" for a. (Resident made negative statements), d. (Persistent anger with self or others), e. (Self deprecation), m. (Crying, tearfulness); remaining Mood items would be coded "0".**

2. Mood Persistence

Intent: To identify if one or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over the last seven days.

Process: Observe the resident and discuss the situation with direct caregivers over all shifts, if possible, and family members or friends who visit frequently or have frequent telephone contact with the resident.

Coding: Enter **"0"** if the resident did not exhibit any mood indicators over last 7 days, "1" if indicators were present and easily altered by staff interactions with the resident or "2" if any indicator was present but not easily altered (e.g., behavior persisted despite staff efforts to console resident).

3. Change in Mood

Intent: To document changes in the resident's mood as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition: Change in Mood — Refers to status of any of the symptoms (new onset, improvement, worsening) described in item El (verbal expressions of distress, sleepcycle issues, sad apathetic, anxious appearance, loss of interest or other signs) and item E2 (mood persistence). Such changes include:

- increased or decreased numbers of expressions or signs of distress
- increased or decreased frequency of distress occurrence
- increased or decreased intensity of expressions or signs of distress

Process: Review the clinical records including the last Quarterly Assessment findings and transmittal records of newly admitted residents. Interview and observe the resident. Consult with staff from all shifts, if possible, to clarify your observations.

Coding: Code "0" if No Change, "1" if Improved, or "2" if Deteriorated as compared to status of 90 days ago.

Examples of Changes in Mood

Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About two months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital for evaluation and treatment. Since her return to the nursing home three weeks ago, her mood and appetite have improved while on a new lithium dose and an additional antidepressant drug. She is back to her "old self" of 90 days ago. **Code "0" for No change.**

During the admission assessment period of 90 days ago, **Mr. M was tearful and** expressed great sadness and anger over entering the nursing home. He had difficulties falling asleep at night, was restless off and on during the night, and awakened too early in the morning, upset that he couldn't fall back to sleep. Since that time, Mr. M has been involved in a twice weekly support group, and has been enjoying socializing in activities with new friends. He is currently sleeping through the night and feels well in the morning. Although he still expresses sadness and anger over his need for nursing home care, it is less frequent and intense. **Code "1" for Improved.**

Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was too restless. After the medication was discontinued, intensity of feelings and behaviors diminished and she has less' frequent episodes of agitation. Mrs. D is better than she was, but she still has feelings of sadness. Mrs. D is now better than her worst status two months ago, but she has not fully recovered to her status of 90 days ago. Code **"2"** for Deteriorated.

During the admission assessment 6 weeks ago, Mrs. Z was very agitated. She had multiple daily complaints of vague aches and pains, She repetitively asked the nurses to "Call the doctor, I'm sick". After no physical problems could be identified, Mrs. Z was evaluated by a psychiatrist who diagnosed a clinical depression and prescribed an antidepressant drug. Its effect on Mrs. Z has been dramatic. During this Significant Change assessment, Mrs. Z had many fewer complaints about her health and was more involved in unit activities. Code **"1"** for Improved.

4. Behavioral Symptoms

Intent: To identify a.) the frequency and b.) alterability of behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents or staff members. Such behaviors include those that are potentially harmful to the resident himself or herself or disruptive in the environment, even if staff and other residents appear to have adjusted to them (e.g.,

"Mrs. R's calling out isn't much different than others on the unit. There are many noisy residents;" or "Mrs. L doesn't mean to hit me. She does it because she's confused. ")

Acknowledging and documenting the resident's behavioral symptom patterns on the MDS provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care towards ameliorating the behavioral symptoms. Documentation in the clinical record of the resident's current status may not be accurate or valid, and it is not intended to be the one and only source of information. (See Process below). However, once the frequency and alterability of behavioral symptoms is accurately determined, subsequent documentation should more accurately reflect the resident's status and response to interventions.

Definition: Wandering — Locomotion with no discernible, rational purpose.-A wandering resident may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair.

Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering, and if it occurs, it should be documented in Item Eln, "Repetitive physical movements".

Verbally **Abusive Behavioral Symptoms** — Other residents or staff were threatened, screamed at, or cursed at.

Physically Abusive Behavioral Symptoms — Other residents or staff were hit, shoved, scratched, or sexually abused.

Socially Inappropriate/Disruptive Behavioral Symptoms — Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

Resists care — Resists taking medications/injections, ADL assistance or help with eating. This category does not include instances where the resident has made an informed choice not to follow a course of care (e.g., resident has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment).

Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the resident's responses to nursing interventions and to prompt further

investigation of causes for care planning purposes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with me&cation errors and unacceptable care, desire to modify care being provided).

Process: Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording any behavioral symptoms. The fact that staff 'have become used to the behavior and minimize the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptom or not? Is the resident combative during personal care and strike out at staff or not?

Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care on all three shifts. A symptomatic behavior can be present and the RN Assessment Coordiitor might not see it because it occurs during intimate care on another shift. Therefore, it is especially important that input from all nurse assistants having contact with the resident be solicited.

Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (e.g., staff are working with severely cognitively and functionally impaired residents and. are used to residents' wandering, noisiness, etc.). Focus staff attention on what has been the individual resident's actual behavior over the last seven days. Finally, although it may not be complete, review the clinical record for documentation.

Coding:

(A) Behavioral symptom frequency in last 7 days.

Record the frequency of behavioral symptoms manifested by the resident across all three shifts.

Code **"0"** if the described behavioral symptom was not exhibited in last seven days.

For each type of behavior described on the MDS form, Code "0" if the resident did not exhibit that type of symptom in the last seven days. This code applies to residents who have never exhibited the behavioral symptom or those who have previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, restraints, or a behavior-management program. For example: A "wandering" resident who did not wander in the last seven days because he

was restricted to a geri-chair would be coded "0" — Behavioral symptom not exhibited in last seven days. The questionable clinical practice of restricting wandering by placing a person in a geri-chair to restrict movement would then be evaluated using the Physical Restraints RAP.

Code **"1"** if the described behavioral symptom occurred 1 to 3 days, in last 7 days.

Code **"2"** if the described behavioral symptom occurred 4 to 6 days, but less than daily.

Code **"3"** if the described behavioral symptom occurred daily or more frequently (i.e., multiple times each day).

(B) Behavioral symptom alterability in last 7 days.

Code **"0"** if **either** the behavioral symptom was not present or the behavioral symptom was easily altered with current interventions.

Code "1" if the described behavioral symptom occurred with a degree of intensity that is not responsive to staff attempts to reduce the behavioral symptom through limit setting, diversion, adapting unit routines to the resident's needs, environmental modification, activities programming, comfort measures, appropriate drug treatment, etc. For example: A cognitively impaired resident who hits staff during morning care and swears at staff with each physical contact on multiple occasions per day, and the behavior is not easily altered, would be coded "1".

Examples for Wandering	(A) Frequency	(B) Alterability
Ms. T has dementia and is severely impaired in making decisions about daily life on her unit. She is dependent on others to guide her through each day. When she is not involved in some type of activity (leisure, dining, ADLs, etc.) she wanders about the unit. Despite the repetitive, daily nature of her wandering, this behavior is easily channeled into other activities when staff redirect Ms. T by inviting her to activities. Ms. T is easily engaged and is content to stay and participate in whatever is going on.	3	0
Mr. W has dementia and is severely impaired in making daily decisions. He wanders all around the residential unit throughout each day. He is extremely hard of hearing and refuses to wear his hearing aid. He is easily frightened by others and cannot stay still for activities programs. Numerous attempts to redirect his wandering have been met with Mr. W hitting and pushing staff. Over time, staff have found him to be most content while he is wandering within a structured setting.	3	1

5. Change in Behavioral Symptoms

intent: To document whether the behavioral symptoms or resistance to care exhibited by the resident remained stable, increased or decreased in frequency of occurrence or alterability as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). Consider changes in any area, including (but not limited to) wandering, symptoms of verbal or physical abuse or aggressiveness, socially inappropriate behavior, or resistance to care. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition: Change in **behavioral symptoms** — refers to the status (new onset, improvement, worsening) of any of the symptoms described in item E4 (Behavioral Symptoms). Such changes include:

- increased or decreased numbers of behavioral symptoms
- increased or decreased frequency of behavioral symptoms occurrence
- increased or decreased intensity of behavioral symptoms
- increased or decreased alterability of behavioral symptoms.

Process: Review nursing notes and resident's records, including the last Quarterly Assessment findings and transmittal records of newly admitted residents. Observe the resident. Consult with direct care staff across all shifts, if possible, and family to clarify your observations.

Coding: Code **"0"** if no change has occurred in behavioral symptoms. This code should also be used for the resident who has no behavioral symptoms currently or 90 days ago.

Code **"1"** (Improved) if the behavioral symptoms became fewer, less frequent, less intense, and were not complicated by the onset of additional behavioral symptoms as compared to 90 days ago.

Code **"2" (Deteriorated) if the** behavioral symptoms became more frequent or more intense or were complicated by the onset of additional behavioral symptoms as compared to 90 days ago.

Examples of Change in Behavioral Symptoms

Despite staff efforts to provide support and structure over the last 90 days, Mrs. H continues to hoard food in her room every day. Staff understand the needs of this formerly homeless woman, but because they have found ants and cockroaches in her room, they feel a need to reevaluate their approach to care. Code **"0"** for No change since last assessment.

During the seven day assessment period, Mrs. D had a difficult time with bowel regularity. She had a history of constipation that became worse during an episode of pneumonia and poor fluid intake that resulted in dehydration. During this time Mrs. D was more confused and subdued. She was found on several occasions during the assessment period disimpacting herself and smearing feces (Socially Inappropriate/Disruptive Behavior). Upon examination Mrs. D was found to have a fecal impaction. She received treatment and was placed on a bowel regimen. The program was successful in eliiting the socially inappropriate behavioral symptoms that was induced by discomfort. However, once Mrs. D started to feel better and was more alert, she resumed her former daily wandering (of 4 months ago), pushing others and rummaging through their dresser drawers. Code **"0"** for No change since last assessment.

Mrs. F has always been a quiet passive woman who has never exhibited any behavioral symptoms since her admission to the nursing home. During this Significant Change assessment following Mrs. F's stroke, no problematic behavioral symptoms were noted. **Code "0" for No change since last assessment.**

(continued on next page)

Examples of Change in Behavioral Symptoms
(c o n t i n u e d)

Mr. C wanders in and out of other residents' rooms and rummages through their belongings at least once a day and sometimes more often. Despite this behavior, during the last few weeks, he has been easier to work with now. that he is more familiar with staff. Although wandering and rummaging continue, he no longer screams, curses, and shoves residents and staff who try to stop this behavior as he did 90 days ago. Code **"1"** for Improved. .

Ninety days ago Mrs. R banged her cane loudly and repetitively on the dining/activity room table about once a week. In the past **week, staff** have noticed that this socially inappropriate **behavioral** symptom (disruptive sounds) now occurs multiple times daily. Code **"2"** for Deteriorated.

SECTION F.
PSYCHOSOCIAL WELL-BEING

Intent: To determine the resident's emotional adjustment to the nursing facility, including his or her general attitude, adaptation to **surroundings,** and change in relationship patterns..

1. Sense of Initiative/Involvement

Intent: To assess the degree to which the resident is involved in the life of the nursing home and takes initiative in participating in various social **and** recreational programs, including solitary pursuits.

Definitions: At ease interacting **with others —** Consider how the resident behaves during the time you are together, as well as reports of how the resident behaves with other residents; staff, and visitors. A resident who tries to shield himself or herself from being with others, spends most time alone, or becomes agitated when visited, is not "at ease interacting with others."

At ease doing **planned** or structured activities — Consider how the resident responds to organized social or recreational activities. A resident who feels comfortable with the structure or not restricted by it is "at ease doing planned or structured activities, " A resident who is unable to sit still in organized group activities and either acts disruptive or makes attempts to leave, or refuses

to attend any such activities, is not "at ease doing planned or structured activities."

At ease doing self-initiated activities — These include leisure activities (e.g., reading, watching TV, talking with friends), and work activities (e.g., folding personal laundry, organizing belongings). A resident who spends most of his or her time alone and unoccupied, or who is always looking for someone to find something for him or her to do, is not "at ease doing self-initiated activities."

Establishes own goals — Consider statements the resident makes, such as "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say good&ye to a loved one. However, some goals may not actually be verbalized by the resident, but inferred in that the resident is observed to have an individual way of living at the facility (e.g., organizing own activities or setting own pace).

Pursues involvement in life of facility — In general, consider whether the resident partakes of facility events, socializes with peers, and discusses activities as if he or she is part of things. A resident who conveys a sense of belonging to the community represented by the nursing home or the particular nursing unit is "involved in the life of the facility."

Accepts invitations into most group activities — A resident who is willing to try group activities even if later deciding the activity is not suitable and leaving, or who does not regularly refuse to attend group programs, "accepts. invitations into most group activities."

Process: Selected responses should be confirmed by objective observation of the resident's behavior (either verbal or nonverbal) in a variety of settings (e.g., in own room, in unit dig room, in activities room) and situations (e.g., alone, in one-on-one situations, in groups) over the past seven days. The primary source of information is the resident. Talk with the resident and ask about his or her perception (how he or she feels), how he or she likes to do things, and how he or she responds to specific situations. Then talk with staff members who have regular contact with the resident (e.g., nurse assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Remember, it is possible for discrepancies to exist between how the resident sees himself or herself and how he or she actually behaves. Use your best clinical judgment as a basis for planning care.

Coding: Check all that apply. None of the choices are to be construed as negative or positive. Each is simply a statement to be checked if it applies and not checked if it does not apply. If you do not check any items in Section F1, check *NONE*

OF *ABOVE*. For individualized care-planning purposes, remember that information conveyed by unchecked items is no less important than information conveyed by checked items.

2. Unsettled Relationships

Intent: To indicate the quality and nature of the resident's interpersonal contacts (i.e., how the resident interacts with staff members, family, and other residents).

Definition: **Covert/open** conflict. with or repeated criticism of staff — The resident chronically complains about some staff members to other staff members, verbally criticizes staff members in therapeutic group situations causing disruption within the group, or constantly disagrees with routines of daily life on the unit. Checking this item does not require any assumption about why the problem exists or how it might be remedied.

Unhappy with **roommate — This category also** includes "bathroom mate" for residents who share a private bathroom. Unhappiness may be manifested by frequent requests for roommate changes, or grumbling about "bathroom mate" spending too long in the bathroom, or complaints about roommate rummaging in one's belongings, or complaints about physical, mental, or behavioral status of roommate. Other examples of roommate compatibility issues include early bedtime vs. staying up and watching TV, neat vs. sloppy maintenance of personal area, roommate spendiig too much time on the telephone, or snoring, or odors from incontinence or poor hygiene.

Unhappy with residents other than roommate — May be manifested by chronic complaints about the behaviors of others, poor quality of interaction with other residents, or lack of peers for socialization. This definition refers to conflict or disagreement outside of the range Of normal criticisms or requests (i.e., repetitive, ongoing complaints beyond a reasonable level).

Openly expresses con&t/anger with family/friends — Includes expressions of feelings of abandonment, ungratefulness on part of family, lack of understanding by close friends, or hostility regarding relationships with family or friends.

Absence of personal contact with family/friends — Absence of visitors or telephone calls from others in the last seven days.

Recent loss of close family member/friend — Includes relocation of family -member/friend to a more distant location, even temporarily (e.g., for the winter months), incapacitation or death of a significant other, or a significant

relationship that recently ceased (e.g., a favorite nurse assistant transferred to work on another unit).

Does not adjust easily to change in routines — Signs of anger, prolonged confusion, or agitation when changes in usual routines occur (e.g., staff turnover or reassignment; new treatment or medication routines; changes in activity or meal programs; new roommate).

Example

For the past 6 months Mrs. A has been receiving 2 white pills, 1 blue pill, 1 yellow pill and 2 puffs of medication from an orange hand-held aerosol inhaler. The drug company that makes the inhaler recently changed its packaging. When Mrs. G is given the new blue inhaler to use and is told that it is the same drug with a different color holder, she becomes very agitated and upset. It takes a lot of patience and reassurance by the nurse before Mrs. G uses the new inhaler. This happened for several days during the past week.

Process: Ask the resident for his or her point of view. Is he or she generally content in relationships with staff and family, or are there feelings of unhappiness? If the resident is unhappy, what specifically is he or she unhappy about?

It is also important to talk with family members who visit or have frequent telephone contact with the resident. How have relationships with the resident been in the last seven days?

During routine nursing care activities, observe how the resident interacts with staff members and other residents. Do you see signs of conflict? Talk with direct-care staff (e.g., nurse assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that some staff members describing these relationships may be biased. As the evaluator, you are seeking to gain an overall picture, a consensus view.

Coding: Check all that apply over the last seven days. If none apply, check *NONE OF ABOVE.*

3. Past Roles

Intent: To document the resident's recognition or acceptance of feelings regarding previous roles or status now that he or she is living in a nursing home.

Definition: **Strong** identification **with past** roles and life status — This may be indicated, for example, when the resident enjoys telling stories about his or her past, or takes pride in past **accomplishments** or **family** life, or continues to be connected with prior lifestyle (e.g., celebrating family events, carrying on life-long traditions).

Expresses sadness/anger/empty feeling over **lost roles/status** — Resident expresses feelings such **as** "I'm not the man I used to be" or "I wish I had been a better mother to my children" or "It's no use, I'm not capable of doing things **I** like -to do anymore." Resident cries when reminiscing about past failures, accomplishments, memories.

Resident **perceives that daily routine (customary routine, activities) is very different from prior pattern in the community — In** general, the resident's **pattern** of routines is perceived by the resident not to be comparable with his or her previous lifestyle.

Examples

In the nursing home, resident takes a shower 2 mornings a week vs. taking a daily tub bath before going to bed as she did at home.

The resident now retires at 7 pm whereas at home he stayed up to watch the 11 pm news.

In the community Mrs. L enjoyed multiple daily telephone conversations with her **5** daughters. In the nursing home there is only one public telephone that seems to be in constant use by residents and staff. Mrs. L now speaks with each daughter only once a week.

Process: **Initiate** a conversation with the resident about life prior to nursing home **admission.** It is **often** helpful to use environmental cues to prompt discussions (e.g., family photos, grandchildren's letters or art work). This information may emerge **from** discussions around other MDS topics (e.g., Customary Routine, Activity Pursuits, **ADLs). Direct** care staff and family visitors may also have useful insights.

Coding: Check item if it applies over the last seven days. If none apply, Check NONE *OF ABOVE.*

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

Most nursing home residents are at risk of physical decline. Most residents also have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Due to these many, possibly adverse influences, a resident's potential for maximum functionality is often greatly underestimated by family, staff, and the resident himself or herself. Thus, all residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs. Individualii plans of care can be successfully developed only when the resident's self-performance has been accurately assessed and the amount and type of support bemg provided to the resident by others has been evaluated.

1. (A) Activities of Daily Living (ADL) Self-Performance

Intent: To record the resident's self-care performance in **activities of daily living (i.e.,** what the resident actually did for hiielf or herself and/or how much verbal or physical help was required by staff members) during the last seven **days.**

Definition: **ADL SELF-PERFORMANCE** — Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

Bed Mobility — How the resident moves to and from a lying position, turns side to side, and positions body while in bed.

Transfer — How the resident moves between surfaces — i.e., to/from bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

Walk in room — How resident walks between locations in his/her room.

Walk in corridor — How resident walks in corridor on unit.

Locomotion on unit — How the resident moves between locations in his or her room and adjacent corridor on the same floor. If the resident is in a wheel-chair, locomotion is defined as self-sufficiency once in the chair.

Locomotion off unit — How the resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If the facility has only one floor, locomotion off the unit is defined as how the resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.

Dressing — How the resident puts on, fastens, and takes off all items of street clothing, including donning/removing a prosthesis.

Eating — How the resident eats and drinks, regardless of skill. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

Toilet Use — How the resident uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.

Personal Hygiene — How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

Bathing — How the resident takes a full-body bath/shower, sponge bath, and transfers in/out of tub/shower. Exclude washing of back and hair.

Process: In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.)

A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nurse assistant he or she lies), and medications. The responsibility of the person completing the assessment; therefore, is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day — i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

In order to accomplish this, it is necessary to gather information from multiple sources — i.e., interviews/discussion with the resident and direct care staff on all three shifts, including weekends and review of documentation used to communicate with staff across shifts. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the resident moves to and from a lying position, how the resident turns from side to side, and how

the resident positions himself or herself while in bed. A resident can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The wording used in each coding option is intended to reflect real-world situations in nursing homes, where slight variations are common. Where variations occur, the coding ensures that the resident is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Supervision, Liited Assistance, and Extensive Assistance) permit one or two exceptions for the provision of heavier care. This is clinically useful and increases the likelihood that staff will code ADL Self-Performance items consistently and accurately.

Because this section involves a two-part evaluation (Item G1A. ADL Self-Performance and Item G1B, ADL Support), each using its own scale, it is recommended that you complete the Self-Performance evaluation for all ADL Self-Performance activities before beginning the ADL Support evaluation.

To evaluate a resident's ADL Self-Performance, begin by reviewing the documentation in the clinical record. Talk with clinical staff from each shift to ascertain what the resident does for himself or herself in each ADL activity as well as the type and level of staff assistance being provided. As previously noted, be alert to differences in resident performance from shift to shift, and apply the ADL codes that capture these differences. For example, a resident may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the resident would be coded as "2" (Limited Assistance) in Toilet Use.

The following chart provides general guidelines for recording accurate ADL Self-Performance and ADL Support assessments.

Guidelines for Assessing ADL Self-Performance and ADL Support

- **The scales in Items G1A** and **G1B** are used to record the resident's actual level of involvement in **self-care** and the type and amount of support actually received during the last seven days.
- Do not record your assessment of the resident's capacity for involvement in **self-care** — i.e., what you believe the resident might be able to do for himself **or** herself based on demonstrated skills or physical attributes. An assessment **of** potential capability is covered in Item G8 **("ADL** Functional Rehabilitation Potential").
- Do not record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The type and level of a&stance actually provided may be quite different **from** what is indicated in the plan. Record what is actually happening.
- Engage direct care staff **from** all shifts who have cared for the resident over the last seven days in discussions **regarding** the resident's ADL functional **performance.** Remind staff that the focus is on the last seven days only. To clarify your own **understanding** and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and **proceeding** to the more specific.

Here is a typical conversation between the RN Assessment Coordinator and a nurse assistant regarding a resident's Bed **Mobility** assessment:

R.N. "Describe to me how Mrs. L positions herself in bed. By that I mean, once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side, and positioning **herself?"**

N.A. "She can lay down and sit up by herself, but I help her turn on her side."

R.N. "She lays down and sits up without any verbal instructions or physical help?"

N.A. "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

R.N. "How do you help her turn side to side?"

N.A. "She can help turn herself by grabbing onto her siderail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

R.N. "Do you lift her by yourself or does someone help you?"

N.A. "I do it by myself."

R.N. "How many days during the last week did you give this type of help?

N.A. "Every day."

Provided that ADL function in Bed Mobility was similar on all shifts, Mrs. L would receive an ADL Self-Performance Code of "3" (Extensive Assistance) and an ADL Support Provided Code of "2" (one person physical assist).

Now review the first two exchanges in the conversation between the RN Assessment Coordinator and nurse assistant. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of either the resident's skills or the nurse assistant's actual workload, or whether the current plan of care was being implemented.

Coding: For each ADL category, code the appropriate response for the resident's actual performance during the past seven days. Enter the code in column (A), labeled "SELF-PERF." Consider the resident's performance during all shifts, as functionality may vary. In the pages that follow two types of supplemental instructional material are presented to assist you in learning how to use this code: a schematic flow chart for scoring ADL Self Performance and a series of case examples for each ADL.

In your evaluations, you will also need to consider the type of assistance known as "set-up help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the nurse assistant). Set-up help is recorded under ADL Support Provided (Item G1B). But in evaluating the resident's ADL Self-Performance, include set-up help within the context of the "0" (Independent) code. For example: If a resident grooms independently once grooming items are set up for him, code "0" (Independent) in Personal Hygiene.

0. Independent — No help or staff oversight -OR- Staff help/oversight provided only one or two times during the last seven days.

1. Supervision — Oversight, encouragement, or cueing provided three or more times during last seven days -OR- Supervision (3 or more times) plus physical assistance provided only one or two times during last seven days.

2. Limited Assistance — Resident highly involved in activity, received physical help in guided maneuvering of limbs or other nonweight-bearing assistance on three or more occasions -OR- limited assistance (3 or more times) plus more help provided only one or two times during last seven days.

3. Extensive Assistance — While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:

   — Weight-bearing support provided three or more times
   — Full staff performance of activity (3 or more times) during part (but not all) of last seven days

4. **Total Dependence** — Full staff performance of the activity during entire seven-day period. Complete non-participation by the resident in all aspects of the ADL definition.

   For example: For a resident to be coded as totally dependent in Eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

8. **Activity did not occur during the entire 7-day period** — Over the last seven days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.

   For example: The definition of Dressing specifies the wearing of street clothes. During the seven day period, if the resident did not wear street clothing, a code of "8" would apply (i.e., the activity did not occur during the entire seven day period). Likewise, a resident who was restricted to bed for the entire seven day period and was never transferred from bed would receive a code of "8" for Transfer.

   However, do not confuse a resident who is totally dependent in an ADL activity (code 4 — Total Dependence) with the activity itself not ocauring. For example: Even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A resident who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as "4".

   Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited Assistance, non weight-bearing supervision or physical assistance must increase from one or two times up to three or more times during the last seven days.

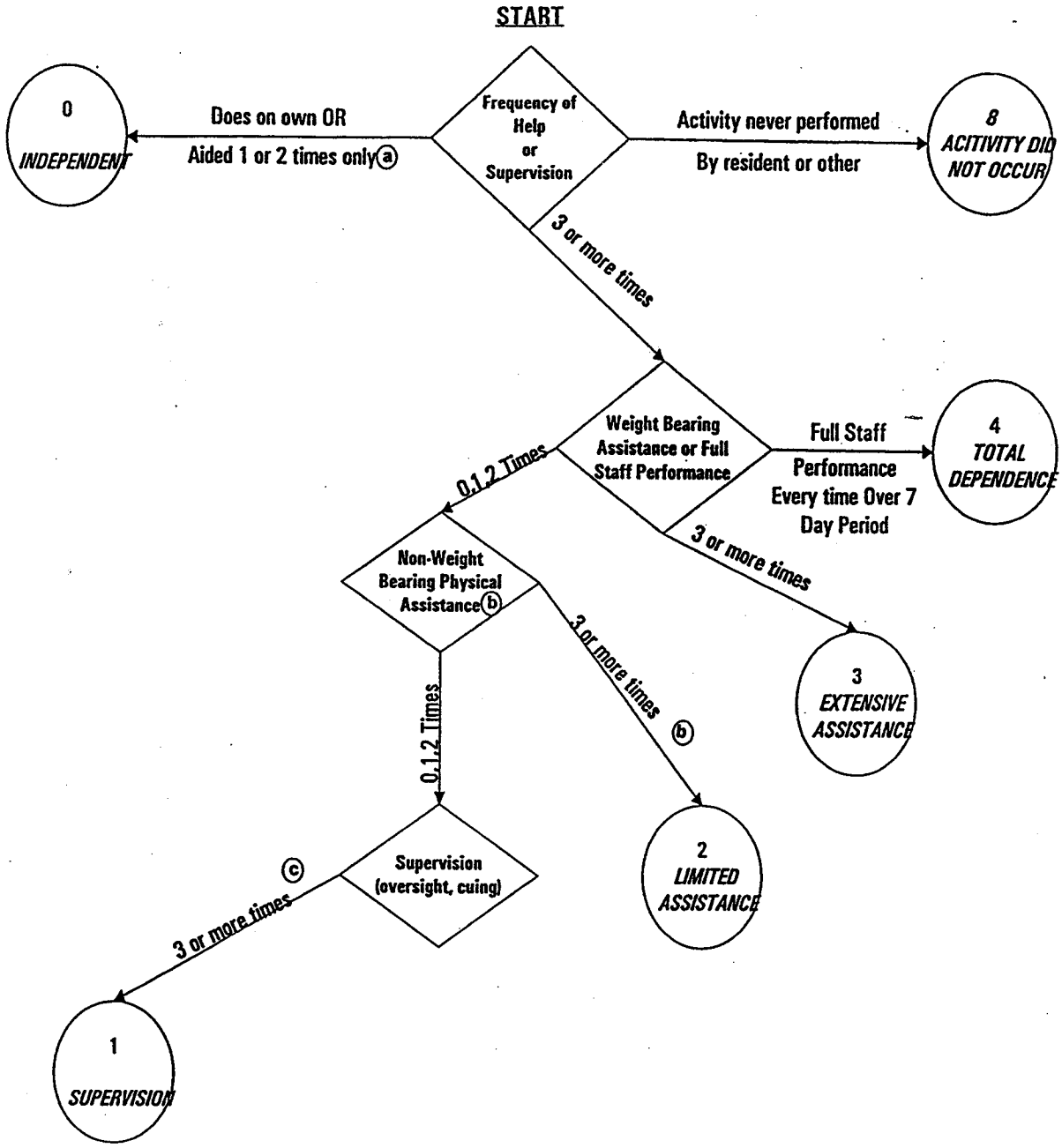
There will be times when no one type or level of assistance is provided to the resident 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent self-performance category where the resident received that level or more dependent support 3 or more times during the 7-day period.

Examples

The resident received supervision for walking in the corridor on two occasions and non weight-bearing assistance on two occasions. **Code "1" for Supervision in Walking in Corridor. Rationale:** Supervision is the least dependent category.

The resident received supervision in dressing on one occasion, non weight-bearing assistance (IE, putting a hat on resident's head) on two occasions, and weight-bearing assistance (IE, lifting resident's arm into a sleeve) on one occasion during the last 7 days. **Code "2" for Limited Assistance in Dressing. Rationale:** There were 3 episodes of physical assistance in the last 7 days: 2 non-weight-bearing episodes, and 1 weight-bearing episode. Limited Assistance is the correct code because it reflects the least dependent support category that encompasses 3 or more activities that were at least at that level of support.

SCORING ADL SELF PERFORMANCE



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a. Can include one or two events where received supervision, non-weight bearing help, or weight bearing help.

b. Can include one or two episodes of weight bearing help--e.g., two events with non-weight bearing plus two of weight bearing would be coded as a "2".

c. Can include one or two episodes where physical help received--e.g., two episodes of supervision, one of weight bearing, and one of non-weight bearing would be coded as a "1".

1. (B) ADL Support Provided

Intent: To record the type and highest level of support the resident received in each ADL activity over the last seven days.

Definition: **ADL Support Provided** — Measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. This is a different scale, and is entirely separate from the ADL Self-Performance assessment.

Set-up help — The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity. This can include giving or holding out an item that the resident takes from the caregiver.

Examples of Setup Help

- **For bed mobility** — handing the resident the bar on a trapeze.
- **For transfer** — giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- **For locomotion:**

  Walking — handing the resident a walker or cane.

  Wheeling — unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **For dressing** — retrieving clothes from closet and laying out on the resident's bed; handing the resident a shirt.
- **For eating** — cutting meat and opening containers at meals; giving one food category at a time.
- **For toilet use** — handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach.
- **For personal hygiene** — providing a wash basin and grooming articles.
- **For bathing** — placing bathing articles at tub side within the resident's reach; handing the resident a towel upon completion of bath.

Process: For each ADL category, code the maximum amount of support the resident received over the last seven days irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the resident's Self-Performance evaluation. For example, a resident could have been Independent in ADL Self-Performance in Transfer but received a one-person physical assist one or two times during the seven-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One person physical assist).

Coding: Note: The highest code of physical assistance in this category (other than the "8" code) is a code of "3" not "4" as in Self-Performance.

0. **No setup or physical help from staff**

1. **Setup help only** — The resident is provided with materials or devices necessary to perform the activity of daily living independently.

2. **One person physical assist**

3. **Two+ persons physical assist**

8. **ADL activity itself did not occur during the entire 7-days** — When an "8" code is entered for an ADL Support Provided category, enter an "8" code for ADL Self-Performance in the same category.

For example, if a resident never left the unit during the assessment period, code "8" for locomotion off unit. The activity did not occur, there was no help provided.

The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the resident descriptions. Cover the answers, read and score the example, and then compare your answers with those provided.

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Bed Mobility		
Resident was physically able to reposition self in bed but had a tendency to favor and remain on his left side. He received frequent reminders and monitoring to reposition self while in bed.	1	0
Resident received supervision and verbal cueing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons.	1	3
Resident usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees, he occasionally slides down towards the foot of the bed. On 3 occasions the night nurse assistant helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard.	3	2
To turn over, the resident always began by reaching for a side rail for support. He received physical assistance of one person to guide his legs into position and complete the turn by guiding him with a turn sheet (using weight-bearing assistance).	3	2
Resident independently turned on his left side whenever he wanted. Because of left-sided weakness he received physical weight bearing help of 1-2 persons to turn to his right side or sit up in bed.	3	3
Because of severe, painful joint deformities, resident was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, she was able to cue staff for the position she wanted to assume and at what point she felt comfortable.	4	3

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Transfer		
Despite bilateral above-the-knee amputations, resident almost always moved independently from bed to wheelchair (and back to bed) using a transfer board he retrieves independently from his bedside table. On one occasion in the past week, staff had to remind resident to retrieve the transfer board. On one other occasion, the resident was lifted by a staff member from the wheelchair back into bed.	0	2
Resident was physically independent for all transfers. However, he would not get up in the morning until the nurse assistant rearranged his bed covers and released the half side rail on his bed.	0	1
Once someone correctly positioned the wheelchair in place and locked the wheels, the resident transferred independently to and from the bed.	0	1
Resident moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely.	2	2
Transferring ability varied throughout each day. Resident received no assistance at some times and heavy weight-bearing assistance of one person at other times.	3	2

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Walk in room		
Resident walked in his/her room while holding on to furniture for support.	0	0
Resident walked independently during the day and received non-weight bearing physical help of 1 person for getting to the bathroom in room at night.	2	2
Resident received non-weight bearing physical assistance of one person for all walking in own room.	2	2
Resident did not walk but wheeled self independently in own room.	8	8
Walk in corridor		
A timid, fearful resident is usually physically independent in walking. During the last week she was very anxious and fearful of falling, and therefore received reassurance and encouragement from someone walking next to her while walking back to her room from meals in the unit dining room.	1	0
A resident with memory loss ambulated independently on the unit corridor albeit with a walker. Several times a day she left her walker in the bathroom, in the dining room, etc., necessitating that someone return it to her and offer her reminders to use it for safety.	1	1
Resident walked in corridor on unit by supporting self on one side with the handrail along the wall and receiving verbal cues from another person.	1	0
Resident walked twice daily 4-6 feet in the corridor outside his room. He received weight bearing assistance of 1 person for each walk.	3	2
Resident walked in room for short distances with heavy assistance of 2 persons but traveled independently in corridor on unit by wheelchair.	8	8

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Locomotion on unit		
Resident ambulated slowly on unit pushing a wheelchair for support, stopping to rest every 15–20 feet. She has good safety awareness and has never fallen. Staff felt she was reliable enough to be on her own.	0	0
A resident with a history of falling and an unsteady gait always received physical guidance (non-weight-bearing) of one person for all ambulation. Two nights last week the resident was found in his bathroom after getting out of bed and walking independently.	2	2
Resident ambulated independently around the unit "ad lib," socializing with others and attending activities during the day. Loves dancing and yoga. Because she can become afraid at night, she received contact guard of one person to walk her to the bathroom at least twice every night.	2	2
During last week resident was learning to walk short distances with new leg prosthesis with heavy partial weight-bearing assistance of two persons. He refuses to ride in a wheelchair.	3	3
Locomotion off unit		
Resident independently walked with a cane to all meals in the Main Dining Room (off the unit) and social and recreational activities in the nearby hobby shop. Received no set-up or physical help during the assessment period.	0	0
Resident walked independently to the off unit dining room for all meals. For one visit to a clinic held at the opposite end of the building she was given a ride in a wheelchair by a volunteer. She was wheeled to the clinic and after her session she was wheeled back to her unit.	0	2
Resident is independent in walking about her residential unit. She does get lost and has difficulty finding her room but enjoys stopping to chat with others. Because she would get lost, she was always accompanied by a staff member for her daily walks around the facility.	1	0
Resident did not leave the residential unit during the 7-day assessment period.	8	8

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Dressing		
Resident usually dressed self. After a seizure, she received total help from several staff members once during the week.	0	3
Resident is totally independent in dressing herself except for donning and removing TED stockings. Nurse assistant applied the TED stockings each AM and removed them at bedtime.	3	2
Nurse assistant provided physical weight-bearing help with dressing every morning. Later each day, as resident felt better (joints were more flexible), she required staff assistance only to undo buttons and guide her arms in/out of sleeves every pm.	3	2
A 325 lb. resident received total care by two persons in dressing. He did not participate by putting arms through sleeves, lifting legs into shoes, etc.	4	3
Eating		
Resident arose daily after 9:00 am, preferring to skip breakfast and just munch on fresh fruit later in the morning. She ate lunch and dinner independently in the facility's main dining room.	0	0
Resident on long standing tube feedings via gastrostomy tube was completely independent in self-administration including self-medication via the tube once set up by staff.	0	1
Resident with a history of dysphagia and choking, ate independently as long as a staff member sat with him during every meal (stand-by assistance if necessary).	1	0
Resident is blind and confused. He ate independently once staff oriented him to types and whereabouts of food on his tray and instructed him to eat.	1	1
Cognitively impaired resident ate independently when given one food item at a time and monitored to assure adequate intake of each item.	1	1
Resident fed self solid foods independently at all meals and snacks. Self-administered all fluids and medications via G-tube with supervision once set up appropriately.	1	1
Resident with difficulty initiating activity always ate independently after someone guided her hand with the first few bites and then offered encouragement to continue.	3	2

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Eating continued		
Resident with fine motor tremors fed self finger foods (e.g., sandwiches, raw vegetables and fruit slices, crackers) but always received supervision and total physical assistance with liquids and foods requiring utensils.	3	2
Resident fed self with staff monitoring at breakfast and lunch but tired later in day. She was fed totally by nursing assistant at supper meal.	3	2
Resident who was being weaned from gastrostomy tube feedings continued to receive total care for twice daily tube feedings. Additionally, she ate small amounts of food by mouth with staff supervision.	3	2
Resident received tube feedings via a jejunostomy for all nutritional intake. Feedings were given by a nurse.	4	2
Toileting Use		
Resident used bathroom independently once up in a wheelchair; used bedpan independently at night after it was set up on bedside table.	0	1
In the toilet room resident is independent. As a safety measure, the nurse assistant stays just outside the door, checking with her periodically.	1	0
Resident uses the toilet independently but occasionally required minor physical assistance for hygiene and straightening clothes afterwards. She received such help twice during the last week.	0	2
When awake, resident was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one person several times each night after incontinence episodes.	3	2
Resident received heavy assistance of two persons to transfer on/off toilet. He was able to bear weight partially, and required only standby assistance with hygiene (e.g., being handed toilet tissue or incontinence pads).	3	3
Obese, severely physically and cognitively impaired resident receives a hoyer lift for all transfers to and from her bed. It is impossible to toilet her and she is incontinent. Complete personal hygiene is provided at least every 2 hours by 2 persons.	4	3

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Personal Hygiene		
New resident, in nursing home adjustment phase, liked to sleep in his clothes in case of fire. He remained in the same clothes for 2–3 days at a time. He cleaned his hands and face independently and would not let others help with any personal hygiene activities.	0	0
Once grooming articles were laid out and arranged by staff, resident regularly performed the tasks of personal hygiene by receiving verbal directions from one person throughout each task.	1	1
Resident carried out personal hygiene but was not motivated. She received daily cueing and positive feedback from nursing staff to keep self clean and neat. Once started, she could be left alone to complete tasks successfully.	1	0
Resident shaves self with an electric razor, washes his face and hands, brushes his teeth, and combs his hair. Because he is losing his sight, staff stand-by to hand grooming articles to the resident and return articles to their proper location.	1	1
Resident performed all tasks of personal hygiene except shaving. The facility barber visited him on the unit three times a week to shave his thick beard.	3	2
Resident required total daily help combing her long hair and arranging it in a bun. Otherwise she was independent in personal hygiene.	3	2

2. Bathing

Bathing is the only ADL activity for which the ADL Self-Performance codes in item G1A do not apply. A unique set of Self-Performance codes, to be used only in the Bathing assessment, are described below. The Self-Performance codes for the other ADL items would not be applicable for bathing given the normal frequency with which the bathing activity is carried out during a one-week period. Assuming that the average frequency of bathing during a seven-day period would be one or two baths, the coding for the other ADL Self- Performance items, which permits one or two exceptions of heavier care, would result in the inaccurate classification of almost all residents as "Independent" for Bathing.

The ADL Support Provided codes given in item G1B, however, continue to apply to the Bathing activity.

Intent: To record the resident's Self-Performance and Support provided in bathing, including how the resident transfers into and out of the tub or shower.

Definition: Bathing — How the resident takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. The definition does not, however, include the washing of back or hair.

Coding: A. **Bathing Self-Performance Codes** -- Record the resident's self-performance in bathing according to the codes listed below. When coding, apply the code number that reflects the maximum amount of assistance the resident received during bathing episodes.

0. **Independent** — No help provided
1. **Supervision** — Oversight help only.
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur during entire 7 days**

B. **Support** -- Next, score the maximum amount of support provided in bathing activities using the ADL Support Scale (Item G1B).

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Bathing		
Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.	1	0
On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, resident had physical help of one person to get into tub but washed himself completely.	3	2
Resident afraid of hoyer lift. Given full sponge or bed bath by nurse assistant twice weekly. Actively involved in this activity.	3	2
For one bath, resident received light guidance of one person to position self in bathtub. However, due to her fluctuating moods, she received total help for her other bath. *Rationale:* The coding directions for bathing state, "code for most dependent in self performance and support."	4	2

3. Test for Balance

Residents with impaired balance in standing and sitting are at greater risk of falling. It is important to assess an individual's balance abilities so that interventions can be implemented to prevent injuries (e.g., strength training exercises; safety awareness; restorative nursing; nursing-based rehabilitation).

Intent: To record the resident's capacity of a.) balance while standing (not walking) without an assistive device or assistance of a person, and b.) balance while sitting without using the back or arms of the chair for support.

Process **a. Balance While Standing**

Preparation:

- Obtain a watch with a second hand to time the test.
- Pick a time to test the resident when he or she is likely to be at his or her best. If the resident refuses, negotiate a better time and try again later.
- Place a chair directly behind the resident in case the resident needs to sit down.
- Stand close to the resident while testing balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.
- Test balance without assistive devices (but with prostheses, if used). For residents who use walkers, make sure the walker is placed directly in front of the resident within easy reach in case it is needed for rebalancing.

Conducting the tests:

- DO each of the following tests (10 seconds each) on residents who are able to stand without physical help.
- DO NOT attempt to test residents who cannot stand by themselves. Code these residents as "3", Not able to attempt test without physical help.
- For persons with visual impairment who may not be able to see your demonstrations of feet placement, provide rich verbal descriptions.

Position 1 —

"I would like you to stand with your feet together, side-by-side, like this (demonstrate as illustrated). [Note, in this and all tests, both feet should be firmly on the floor for support.]

"Do not move your feet until I say stop. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 2. **If the resident is NOT ABLE to maintain this position for 10 seconds, stop testing here.** Do not proceed with Position 2 for balance testing.

Position 2 —

"Now I would like you to stand with one foot halfway in front of the other like this" (demonstrate as illustrated).

"You may use either foot, whichever is more comfortable for you. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 3. **If the resident is NOT ABLE to do this, stop testing here.**

Position 3 —

"Now I would like you to stand with the heel of one foot in front of you touching the toes of the other foot like this (demonstrate as illustrated). You may use either foot, whichever is more comfortable for you. Ready, OK, begin."

Coding:

0. **Maintained position as required in test** — Resident was able to maintain all 3 standing positions for 10 seconds without moving feet out of position.

1. **Unsteady, but able to rebalance self without physical support** — Resident was unable to maintain one or more standing positions for 10 seconds each without moving feet out of position. Resident was unsteady but was able to rebalance self without physical support from others or from an assistive device in at least the first position.

2. **Partial physical support during test, or stands but does not follow directions for test** — While the resident performed part of the activity, resident was unable to maintain one or more standing positions without physical support from other(s) or from an assistive device. This category also includes residents who can stand but are unable or refuse to follow your directions to perform a test of balance.

3. **Not able to attempt test without physical help** — Resident is not able to stand without physical help from another person or an assistive device.

Examples of Balance Testing

Mrs. R usually walks with a walker. After completing the test preparation steps for safety, which include placing Mrs. R's walker directly in front of her in case she needs it during the test, you briefly explain to Mrs. R what you are going to ask her to do. You also demonstrate the actions. Once Mrs. R is standing, start to test her in Position 1 by giving her the brief directions and your demonstration of the position. You start timing her once you say, "Ready, OK, begin".

Results: During the 10-second test, Mrs. R moves her feet out of position to rebalance herself.

How to proceed: Tell Mrs. R, "That was a good try." STOP the test because the next 2 positions are harder to perform. If Mrs. R cannot maintain Position 1, it is unlikely she will be able to maintain Positions 2 or 3.

Coding: "1", Unsteady, but able to rebalance self without physical support.
Rationale: Mrs. R moved her feet out of position but did not need to hold her walker, or lean against the chair behind her, or receive assistance from you during the 10 seconds.

Mr. C has cognitive and hearing impairment and restlessness. He usually walks independently (wandering) and occasionally stands at the nurses' station to be with the unit secretary. Therefore, you know he can stand, but you do not know if he would be able to maintain his balance if her were asked to "hold" specific standing positions for 10 seconds each. After completing the test preparation, and steps for safety, you give Mr. C the brief directions and demonstration for testing position 1.

Results: During your interaction with Mr. C he becomes agitated, says "No, no" and walks away.

How to proceed: STOP the test.

Coding: "2", Partial physical support during test or stands but does not follow directions for test. ***Rationale:*** This is the best you can do under the circumstances. Although Mr. C did not need physical help to balance, you really do not know what his true balance capacity is. All you know is that he is able to stand, but you can't test his balance capacity because he refuses and is unable to follow directions.

Ms. M has multiple sclerosis and has been confined to her bed and reclining chair for the last 2 years.

How to proceed: DO NOT perform any standing balance tests. Ms. M cannot stand.

Coding: "3", Not able to attempt test without physical help.

Process: **b. Balance while sitting — position, trunk control**

Preparation

- Obtain a watch with a second hand to time the test.
- Do not conduct sitting balance in wheelchair. Find a chair with a firm, solid seat to conduct the test.
- The height of the chair seat should be low enough to allow the bottom of the resident's feet to rest on the floor for support. (Of course, this does not apply to persons with bilateral leg amputations.)
- It is safer to use a chair with arms in case the resident needs physical support during the test.
- Stand close to the resident while testing sitting balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

Conducting the test:

- DO NOT attempt to test residents who are clearly unable to sit without physical help. Code these residents as "3", Not able to attempt test without physical help.
- Instruct the resident to sit in a chair with arms folded across his or her chest without using the back or arms of the chair for support. Make sure the resident's feet are both flat on the floor for support. Demonstrate the action to the resident. Observe balance for 10 seconds, then ask resident to stop.

Coding:

0. **Maintained position as required in test** — Resident was ABLE to sit for 10 seconds without touching the back or sides of the chair for support.
1. **Unsteady, but able to rebalance self without physical support.** — Resident was unable to maintain sitting balance for 10 seconds without touching the back or sides of the chair for support. Resident was unsteady but was ABLE to rebalance self.
2. **Partial physical support by others during test or sits but does not follow directions for test** — While resident performed part of activity, resident was UNABLE to maintain sitting balance without physical support from

other(s) or from touching the backs or sides of the chair for support. This category also includes residents who can sit but are unable or refuse to follow your directions to perform this test of sitting balance.

3. **Not able to attempt test without physical help** — Resident is not able to sit without physical help from another, or an assistive/adaptive device, or chair back/arms for support.

Examples of Sitting Balance

Ms. Z spends a lot of time sitting in a wheelchair on a gel cushion for pressure relief. She has a left-sided below-the-knee amputation. She does not have a leg prosthesis. She also has a left-sided hemiparesis from a CVA 1 year ago. You complete the test preparation activities for safety, assist Ms. Z to transfer into a chair with a firm seat, and ask her to place her right foot firmly on the floor. You instruct her to cross her arms over her chest. She cannot lift her left arm across her chest but is able to hold it across her abdomen. You instruct her to "sit up in the chair without leaning on the chair back or arms for support". You demonstrate this activity from another chair. Once the resident begins, you time for 10 seconds.

Results: Ms. Z maintained the position for the full 10 seconds without touching the chair back/arms for support.

How to proceed: Tell Ms. Z, "You did an excellent job. That's all we have to do." STOP testing. The test is complete.

Coding: "0", Maintained position as required in test.

4. Functional Limitation in Range of Motion

(A) Limitation in range of motion.

Intent: **Limitation in the range of motion** — To record the presence of (A) functional limitation in range of joint motion or (B) loss of voluntary movement.

Definition: Limitation that interferes with daily functioning (particularly with activities of daily living), or places the resident at risk of injury.

Process: **Assessing for functional limitations.** This test is a screening item used to determine the need for a more intensive evaluation. It does not need to be performed by a physical therapist. Rather, it can be administered by a member of any clinical discipline in accordance with these instructions.

- Do each of the following tests on all residents unless contraindicated (e.g., recent fracture or joint replacement).
- Perform each test on both sides of the resident's body.
- If the resident is unable to follow verbal directions demonstrate each movement (e.g., Ask the resident to do what you're doing).
- If resident is still unable to perform the activity after your demonstration, move the resident's joints through slow, active assisted range of motion to assess for limitations. In active assistive range of motion exercises, the health professional provides support and direction with the resident performing some of the activity.
- STOP if a resident experiences pain.

Neck — With resident seated in a chair, ask him or her to turn the head slowly, looking side to side. Then ask the resident to return head to center and then try to reach the right ear towards the right shoulder, then left ear towards left shoulder.

Arm — including shoulder or elbow — With resident seated in a chair instruct him or her to reach with both hands and touch palms to back of the head (mimics the action needed to comb hair). Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head.

Hand — including wrist or fingers — For each hand, instruct the resident to make a fist, then open the hand (useful actions for grasping utensils, letting go).

Leg — including hip or knee — While resident is lying supine in a flat bed, instruct the resident to lift his or her leg (one at a time), bending it at the knee. [The knee will be at a right angle (90 degrees)]. Then ask the resident to slowly lower his or her leg, and extend it flat on the mattress.

Foot — including ankle or toes — While supine in bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot.

Other limitation or loss — Decreased mobility in spine, jaw, or other joints that are not listed.

Coding: For each body part, code the appropriate response for the resident's active (or assisted passive) range of motion function during the past seven days. Enter